

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) Wayne Thomas Abbott						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 18 1983		2b. HOUR 0243			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 21 56		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 26		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 18 1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Toddville Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester					
10. CITY OR TOWN OF DEATH Ocean City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 90				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shore Land Foods-Salis.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 610 Liberty St.		21801	
14. FATHER'S NAME FIRST MIDDLE LAST Paul W. Abbott				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Dunn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-68-5853		17. INFORMANT Paul W. Abbott				ADDRESS Box 230 Wingate Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Mutiple Trauma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant	
IMMEDIATE CAUSE (a) 8199 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 0243 P.M. 6 18 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Auto Accident					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Route 90 Ocean City Worcester MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John T Bulkeley				TITLE (SPECIFY) Deputy				DATE SIGNED June 20, 83			
EXAMINER'S NAME (TYPE OR PRINT) John T Bulkeley				ADDRESS Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/21/83		23c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEM PK				23d. LOCATION CITY OR TOWN COUNTY STATE CAMBRIDGE DOR MD			
24. FUNERAL DIRECTOR NAME ADDRESS THOMAS FUNERAL HOME CAMBRIDGE MD.						25a. DATE REC'D. BY REGISTRAR JUN 28 1983 REGISTRAR'S SIGNATURE John J. Carver					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17250					
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) Richard Thomas Allen										ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 20 1983		7 PM			
3. SEX M		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 14 14		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 6 20 1983		2d. HOUR 7:40 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pocomoke, Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Worcester Co. MD.			
10. CITY OR TOWN OF DEATH Snow Hill				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 103 Ross St., at home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.				13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 103 Ross St. 21863					
14. FATHER'S NAME FIRST MIDDLE LAST George Conquest						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Ward									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes						16b. SOCIAL SECURITY NO. 8-42 - 9-45		17. INFORMANT ADDRESS Ernesting Bailey, Snow Hill, Md. 21863							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASHD DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE SEVERAL YRS.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Dorothy C. Holzworth						TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER				DATE SIGNED 6-22-83					
EXAMINER'S NAME (TYPE OR PRINT) DOROTHY C. HOLZWORTH						ADDRESS 309 Timmons St. Snow Hill, Md. 21863									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-24-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Wesley				23d. LOCATION CITY OR TOWN COUNTY STATE Snow Hill - Worcester MD.					
24. FUNERAL DIRECTOR NAME Wharton ADDRESS Wharton Funeral Home, Accomac, Va.						25a. DATE REC'D. BY REGISTRAR JUN 28 1983 REGISTRAR'S SIGNATURE John J. Canish									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

DHMH: 16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 7 2 5 1

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BISHOP			2a. DATE OF DEATH MONTH DAY YEAR 6 28 83			2b. HOUR 6:30a.m.			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 3 5 1895		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.			
10. CITY OR TOWN OF DEATH BERLIN MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY RET.	
13a. STATE MD		13b. COUNTY WOR		13c. CITY OR TOWN SNOW HILL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 216 ROSS ST.	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN TAYLOR				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HESTER BEVANS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-07-6234		17. INFORMANT ADDRESS V. PURWELL SNOW HILL, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4408 IMMEDIATE CAUSE (a) CHRONIC ANEURISM DUE TO, OR AS A CONSEQUENCE OF (b) MI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) AGING APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from JUN 19 83 , to JUNE 19 83 , that (I) (we) last saw the deceased alive on 27-June 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Federico Arthes DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 28-June 83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FEDERICO ARTHES MD				22e. ADDRESS 3 BAY ST. BERLIN, MD. 21811					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-5-83		23c. NAME OF CEMETERY OR CREMATORY MT ZION		23d. LOCATION CITY OR TOWN COUNTY STATE SNOW HILL, MD			
24. FUNERAL DIRECTOR NAME VEL RICH F.A. BERLIN, MD.				25a. DATE REC'D. BY REGISTRAR JUL 7-1983		25b. REGISTRAR'S SIGNATURE John J. Connel			

MEDICAL CERTIFICATION

Alfred Jones 389 F 106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	3	1	7	2	5	2
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>ISAAC TALBOT BURBAGE</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>6 3 83</i>				2b. HOUR <i>7¹⁰ A.M.</i>		
3 SEX <i>MALE</i>		4 RACE <i>CAUCASIAN</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>1 14 06</i>			6 AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS <i>77</i>		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>WORCESTER Co. MD.</i>									
10 CITY OR TOWN OF DEATH <i>SNOW HILL</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HARRISON HOUSE NURSING HOME</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>LANDLORD</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>HOUSING</i>							
13a. STATE <i>VIRGINIA</i>		13b. COUNTY <i>MIDDLESEX</i>		13c. CITY OR TOWN <i>URBANNA</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>VIRGINIA STREET 99999</i>								
14. FATHER'S NAME FIRST MIDDLE LAST <i>William J. BURBAGE</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ELLA TURNER</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>								
16b. SOCIAL SECURITY NO. <i>227-01-8834</i>				17. INFORMANT ADDRESS <i>WILLIAM ST SELBYVILLE</i>				17. INFORMANT <i>MAIE FURMAN BURBAGE</i>								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4149</i> IMMEDIATE CAUSE (a) <i>MYOCARDIAL FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CORONARY ARTERY DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 MINUTES</i> <i>SEVERAL YRS.</i> <i>SEVERAL YRS.</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>DIABETES MELLITUS</i>																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (was <i>hospital</i>) attended the deceased from <i>MAY 19TH</i> , 19 <i>83</i> , to <i>JUNE 3RD</i> , 19 <i>83</i> , that (I) (was) last saw the deceased alive on <i>JUNE 2ND</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.																
22b. SIGNATURE <i>Dorothy C. Holzworth</i>				DEGREE <i>M.D.</i>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6-3-83</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DOROTHY C. HOLZWORTH</i>				22e. ADDRESS <i>309 TIMMONS ST. SNOW HILL, MD. 21863</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>				23b. DATE <i>6/5/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>EVERGREEN</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BEALIN Wor MD.</i>								
24. FUNERAL DIRECTOR NAME <i>Anna A Burbage</i>				ADDRESS <i>108 WILLIAMS ST BROWN MD 21811</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 8 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>						

Groom's Name		Bride's Name	
John Smith		Mary Jones	
Age		Age	
25		22	
Place of Birth		Place of Birth	
Texas		Texas	
Date of Marriage		Date of Marriage	
Jan 1, 1900		Jan 1, 1900	
Place of Marriage		Place of Marriage	
Dallas, Texas		Dallas, Texas	
Minister of the Gospel		Minister of the Gospel	
Rev. J. W. Smith		Rev. J. W. Smith	
Signature of Minister		Signature of Minister	
[Signature]		[Signature]	
Date of Certificate		Date of Certificate	
Jan 1, 1900		Jan 1, 1900	
Place of Issuance		Place of Issuance	
Dallas, Texas		Dallas, Texas	
County		County	
Dallas		Dallas	
State		State	
Texas		Texas	

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	7a. DATE OF DEATH	MONTH	DAY	YEAR	7b. HOUR
WILLIE				CAMPBELL	6	12	83		6A ^M
1. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M	B	MONTH DAY YEAR 8 6 24		58 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Ala.	U.S.A.			Worcester MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Pocomoke	Home - Route I			Laborer		Custodian			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS				
Md.		Worcester	Pocomoke		Rt. I Bx. 284A 21851				
14. FATHER'S NAME (TYPE OR PRINT)		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)		16. SOCIAL SECURITY NO.					
Willie		Campbell Sr.		Mary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO) (UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes		WWII 424-18-8855		Rosie Mae Campbell					
18. CAUSE OF DEATH Enter only one cause per line for a), b), and c		18a. IMMEDIATE CAUSE (a)							
PART I DEATH WAS CAUSED BY:		Respiratory Failure							
4920		DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Emphysema							
		DUE TO, OR AS A CONSEQUENCE OF							
		(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 19 80, to June 19 83, that (I) (we) lost saw the deceased alive on June 11 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Paul R Fleury		MD					6/12/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
PAUL R FLEURY		305 Tenth St Pocomoke City							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR	
Burial		6-19-83		Hall's Hill Cem.		Pocomoke Wbr. Md.		JUN 15 1983	
24. FUNERAL DIRECTOR		25. REGISTRAR'S SIGNATURE							
James J. Carter		New Church, Va.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

OHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Mary F. Cathell						6 25 1983			4:30 A
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		Feb. 17, 1919			64 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
New York		USA					Worcester Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Showell			Pitts Road			Seamstress			Clothing
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
Maryland			Worcester			Showell			Pitts Road 2862
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Wallace Mullen			Frances Butler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			118-09-3374			Patricia Shepherd, Showell, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the Cervix</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
						Apr 1 1983 to 6/25/83			
22a. I certify that (1) (this hospital) attended the deceased from <u>Apr 1 1983</u> to <u>6/25/83</u> , that (1) (we) last saw the deceased alive on <u>5/25/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Ch. Raabman						PO Box 2636 Salisbury MD 21801			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6-28-83		Odd Fellows Cem.		Bishopville, Worc. MD			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles W. Hastings, Selbyville, Del.						DATE JUN 29 1983		John J. Caruth	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 7 2 5 5	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Fannie Kriger			2a. DATE OF DEATH MONTH DAY YEAR 06-11-83		2b. HOUR 10:35a
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 12 26 1896		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH Pocomoke City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartley Hall Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS State Route 50 21613	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Heilig		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Heilig Maiden name Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-56-1041		17. INFORMANT ADDRESS Mr. Bill Goodman, Snow Hill, Md. 21863	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) NATURAL Causes. DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JULY 22, 1981 to June 18, 1983 , that (I) (we) lost the deceased alive on JUNE 3, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.					
22b. SIGNATURE Paul R. Henry		DEGREE		22c. DATE SIGNED 6/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL FLEURY		22e. ADDRESS 305 TENTH ST Pocomoke City Md.			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 6/13/83	23c. NAME OF CEMETERY OR CREMATORY Beth Isarel Cemetery		23d. LOCATION Salisbury Wicomico Md.
24. FUNERAL DIRECTOR NAME Holloway Funeral Home		ADDRESS Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR JUN 16 1983	25b. REGISTRAR'S SIGNATURE John J. Canine

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 7 2 5 6	
FOR 1. STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA LEE THOMPSON						2a. DATE OF DEATH MONTH DAY YEAR June 22, 1983		2b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 3, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD					
10. CITY OR TOWN OF DEATH Pocomoke		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1403 Linden Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel C. Bowen						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 218-16-6560		17. INFORMANT ADDRESS 1403 Linden Drive Lee Ray Thompson Pocomoke City, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction - 4 hour DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) this hospital attended the deceased from July 19 83 , to June 19 83 , that (b) (we) lost saw the deceased alive on 4/25 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) and not view the body after death.											
22b. SIGNATURE Roger C. Merrill		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/27/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger C. Merrill		22e. ADDRESS 1200 Power St. Salisbury, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/26/83		23c. NAME OF CEMETERY OR CREMATORY Salem Methodist Cem. Pocomoke Worcester Md.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Scott S. Nelson		ADDRESS Pocomoke City, Md.		25a. DATE REC'D. BY REGISTRAR JUL 5 1983		25b. REGISTRAR'S SIGNATURE John J. Carney					

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VIRGINIA 222 THOMAS June 22, 1943

female white Nov. 3, 1934
Maryland USA Worcester

ocomeke 1903 Linden Drive
Maryland Worcester ocomeke x 1903 Linden Drive

female brown with Jones
1903 Linden Drive
212-15-6500 by Thompson ocomeke City, Md.

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